MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
P.O. Box 58
Jefferson City, MO 65102-0058

DIVISION INJURY NUMBER (If Known)

CLAIM FOR COMPENSATION

NOTE: This form must be typed or hand printed in **black ink**.

SUBMIT AN ORIGINAL AND THREE COPIES.

☐ ORIGINAL CLAIM ☐ AMENDED CLAIM

ITEM NUMBER(S) AMENDED

EMPLOYEE INFORMATION

1. INJURED EMPLOYEE'S NAME LAST	FIRST	INITIAL OR MIDDLE NAME	1A. STREET ADDRESS		
1B. CITY	1C. STATE	1D. ZIP CODE	2. SOCIAL SECURITY NO.	3. DATE OF ACCIDENT/ OCCUPATIONAL DISEASE	
4. AVERAGE WEEKLY WAGES	5. TIME OF ACCIDENT ☐ A.M. ☐ P.M.	6. PLACE OF ACCIDENT (Address, City, County, State, Zip)			
7. PART(S) OF BODY INJURED					
8. DESCRIBE WHAT THE EMPLOYEE WAS DOING AND HOW THE INJURY OCCURRED.					

EMPLOYER INFORMATION – If additional employers need to be listed, attached a separate sheet or list in Item 14.

9. EMPLOYER(S) AGAINST WHOM THIS CLAIM IS FILED.		
EMPLOYER A:	STREET ADDRESS	
CITY	STATE	ZIP CODE
EMPLOYER B:	STREET ADDRESS	
CITY	STATE	ZIP CODE
EMPLOYER C:	STREET ADDRESS	
CITY	STATE	ZIP CODE

SECOND INJURY FUND CLAIM

10. IS A CLAIM BEING FILED AGAINST THE SECOND INJURY FUND? ☐ YES ☐ NO

IF YES, READ AND COMPLETE THE FOLLOWING FOR ALL PREVIOUS INJURIES.

A. DATE(S) OF OCCURRENCE OF PREVIOUS INJURY(IES) (MM/DD/YY): ___/___/___ ___/___/___ ___/___/___

B. PART(S) OF BODY AFFECTED BY PREVIOUS INJURY(IES) _____

_____

C. DEGREE OR PERCENTAGE OF PREVIOUS DISABILITY AT THE TIME OF THE MOST RECENT INJURY(IES), IF RATED _____

_____

11. NATURE OF CLAIM – CHECK ONE OF THE FOLLOWING:

☐ **PERMANENT PARTIAL DISABILITY** ☐ **PERMANENT TOTAL DISABILITY** ☐ **UNINSURED EMPLOYER**

☐ **SECOND JOB LOST WAGE**

BE SURE TO COMPLETE NEXT PAGE
CLAIM MUST BE SIGNED

12. DID INJURY RESULT IN DEATH? ☐ YES ☐ NO	12A. DATE OF DEATH ___/___/___

If death occurred, **EMPLOYEE'S DEPENDENTS (SPOUSE, MINOR CHILDREN, OTHER PERSONS DEPENDENT ON EMPLOYEE).**
If additional dependents need to be listed, attach a separate sheet or list in Item 14.

13. NAME	DATE OF BIRTH	RELATIONSHIP	EXTENT (%) OF DEPENDENCY	
ADDRESS		ADDRESS	STATE	ZIP CODE
13A. NAME	DATE OF BIRTH	RELATIONSHIP	EXTENT (%) OF DEPENDENCY	
ADDRESS		ADDRESS	STATE	ZIP CODE
13B. NAME	DATE OF BIRTH	RELATIONSHIP	EXTENT (%) OF DEPENDENCY	
ADDRESS		ADDRESS	STATE	ZIP CODE
13C. NAME	DATE OF BIRTH	RELATIONSHIP	EXTENT (%) OF DEPENDENCY	
ADDRESS		ADDRESS	STATE	ZIP CODE

14. ADDITIONAL STATEMENTS

CLAIM IS HEREBY MADE FOR ALL COMPENSATION AS PROVIDED IN THE MISSOURI WORKERS' COMPENSATION LAW, RELATING TO INJURY (OR DEATH) OF THE EMPLOYEE BY ACCIDENT OR OCCUPATIONAL DISEASE ARISING OUT OF AND IN THE COURSE OF THE EMPLOYMENT.

15. INJURED EMPLOYEE OR CLAIMANT'S SIGNATURE	16. EMPLOYEE TELEPHONE NO.	17. DATE
18. CLAIMANT'S ATTORNEY SIGNATURE	18A. CLAIMANT'S ATTORNEY NAME	

18B. BAR NUMBER	19. PHONE NUMBER	20. FAX NUMBER	
21. ATTORNEY ADDRESS	21A. CITY	21B. STATE	21C. ZIP CODE

NOTE: LINE 15 MUST BE SIGNED IN BLACK INK – NOT TYPED.